**Utah Department of Health's Response**
**To Possible Changes to PCN**

The Primary Care Network (PCN) is part of the Medicaid program and operates under authority from the federal government. PCN has been approved from July 2002 to June 2007. For PCN to continue beyond June 2007, the state will need to request that the federal government extend the program. This request must be submitted by June 2006. The Utah Department of Health (department) has met with doctors, hospitals, clinics, and advocates for low income individuals over the last six months to obtain advice on PCN. From these discussions, a list of suggestions were developed.

The department's preliminary response to these suggestions is included below. The department may find it necessary to change these responses based on additional discussion and data that may arise in the next few weeks.

## Benefits

- Narcotics control

The department does not plan to seek this amendment.
PCN currently follows the Medicaid guidelines for narcotics control and will continue to use the existing review procedures to identify potential abuse.

- Preferred Drug List (PDL)

The department plans to seek this amendment.
Medical journals have shown that some less expensive drugs are just as effective as far more expensive drugs. The department would seek the flexibility to identify drug classes where cheaper drugs are available that provide the same benefit. The PPI drug class would be a likely group.

- Develop formulary that is all generic with the exception of drugs without a generic substitute/alternative.

The department does not plan to seek this amendment.
The current prescription drug policy already requires a mandatory generic substitution and the department plans to seek the authority to have a PDL.

- Add Urgent Care (Co-payment suggestions: $20.00/ $25.00/$30.00/$35.00)

The department plans to seek this amendment.
Urgent care provides an important after business hours option to individuals rather than going to the emergency room (ER). In the hopes of obtaining the proper utilization of this benefit, the department will likely charge a $20.00 co-payment.

- Eliminate ER coverage

The department is still considering this proposed amendment.
Option 1 – Retain ER – The department would continue the current practice of covering limited ER visits based on the approved emergency diagnosis list in the current provider manual.

Option 2 – Cut ER – The department would seek to eliminate ER coverage in order to free up funding for other services.

- Coverage for MRI and CT scans when done in conjunction with a covered ER visit

The department is still considering this proposed amendment.
*Note – This change would be contingent on the decision to eliminate ER coverage.*
Option 1 – Retain ER – The department would seek to add coverage for MRI and CT scans when done in conjunction with a covered ER visit and within existing Medicaid protocols. The required co-insurance for this service would likely be 25%.
Option 2 – Cut ER – The department would continue to deny all MRI and CT scans.

- Mental Health (if it cannot be covered try to find providers willing to donate services)

The department does not plan to seek this amendment.
PCN is a limited benefit program; even many private health insurance plans do not have full benefits. Department staff will continue to make efforts to find providers willing to donate mental health services, although there has been limited success in this area in the past.

- Cut vision benefit

The department does not plan to seek this amendment.
PCN seeks to provide preventive health services. Therefore the department believes it is necessary to continue coverage for preventive visits. In addition, cutting this benefit would not provide significant cost savings to the program.

- Outpatient surgery, offset surgeon's cost as we do when client is hospitalized.

The department does not plan to seek this amendment.
Outpatient surgery is not a covered benefit by PCN therefore the department does not believe PCN should offset the surgeon's cost for outpatient procedures.

- Add specialty care

The department is still considering this proposed amendment.
Option 1 – Retain ER – Given the current cost restrictions, there is insufficient funding to allow for the addition of specialty care while retaining all other current services.
Option 2 – Cut ER – If the department were to request the elimination of ER coverage, there may be sufficient funds to add another service like specialty care. This service has been the most requested by clients and advisory groups. The department is considering the possibility of only opening some specialty care categories in order to limit the costs to the available funding. The department is also considering a higher co-payment for these visits – possibly $20.

- Change dental co-insurance of 10% to a fixed dollar co-payment

The department is still considering this proposed amendment.
This amendment would be cost neutral but would hopefully make co-payment collection easier for dentists who would know up front what the co-payment would be. Additional data is being gathered for further review of this suggestion.

- Require PCN client to select a primary care physician and to have an initial visit within 6 months of their effective date of coverage

The department does not plan to seek this amendment.
Insufficient discussion has occurred to date to implement this change as part of the extension package. The department will consider this suggestion in another year. For this suggestion to be implemented a sufficient number of primary care providers would have to be willing to accept PCN clients so that clients could easily arrange an initial visit.

- Cash rebates for health improvements (stop smoking, significant weight loss, cholesterol reduction, etc.)

The department does not plan to seek this amendment.
Insufficient discussion has occurred to date to implement this change as part of the extension package. The department will consider this suggestion in another year.

- Allow clients to choose PCN or a comparable private option for coverage (PCN would contract with private carrier)

The department plans to seek this amendment.
The original legislation that created PCN included the option for insurers to develop comparable plans. If the cost will be neutral to the program, then clients should have the option of choosing a private plan. The department will pursue contracting with a private provider to give PCN clients a choice in plans.

- Contract with a carrier to use physician network (access fee)

The department plans to seek this amendment.
The department will pursue contracting with a carrier to use their physician network. This addition will give PCN clients better access to primary care doctors.

- Eliminate PCN and use all PCN funds to expand Covered at Work

The department plans to seek an extension of the waiver.
The elimination of PCN would cause a large number of low income individuals to lose coverage. A large portion of the PCN population does not have access to employer sponsored health insurance therefore they would not be eligible for Covered at Work. The department will pursue a Health Insurance Flexibility and Accountability (HIFA) demonstration for 1,000 adults to see if employer sponsored health insurance is successful and effective.

**Co-Payment Changes**

- Decrease generic co-payment from $5 to $4

The department does not plan to seek this amendment.
The department is hoping to standardize co-payments at $5 for many basic services. In addition, clients are not allowed to purchase brand name drugs when a generic drug is available; therefore, additional incentive to use generic would not occur by lowering the co-payment.

- Increase vision exam co-payment from $5 to $10

The department does not plan to seek this amendment.
The department is hoping to standardize co-payments at $5 for many basic services.

- Increase x-ray co-insurance from 5% to 10% if the allowed amount is over $100

The department plans to seek a similar amendment.
The department will pursue changing the co-insurance for both lab and x-ray. If the allowed amount is over $50, the co-insurance will be 10%. The department is hoping to standardize co-insurance at 10% for many services.

- Increase office visit co-payment from $5 to $10

The department does not plan to seek this amendment.
The department is hoping to standardize co-payments at $5 for many basic services. An office visit is a basic component of preventative health and increasing the co-payment to $10 may discourage routine visits.

- Increase medical equipment co-insurance from 10% to 15%

The department does not plan to seek this amendment.
The department is hoping to standardize co-insurance at 10% for many services.

- Increase ER co-payment from $30 to $60

The department plans to seek a similar amendment.
The department will pursue increasing the emergency room co-payment from $30 to $40.

- Charge different co-payments for ER based on the type of emergency. Charge higher co-payments for CT scan and MRI

The department does not plan to seek this amendment.
With ER coverage limited to specific true emergency situations, it would be difficult to charge different co-payments based on the discharge diagnosis.

- Increase out of pocket maximum from $1,000 to $1,500

The department plans to seek this amendment.
With rising medical costs, the department will seek to reposition the maximum.

**Eligibility**

- Allow full time students on Covered at Work if they are employed and employer insurance is offered

The department plans to seek this amendment through the HIFA waiver.

- Combine CHIP & PCN into a voucher/credit to be used with the employee's health plan.

The department plans to seek this amendment through the HIFA waiver.

- Structure the program to enable more assistance with employer premium cost.

The department plans to seek this amendment through the HIFA waiver.

- Cover full time students if the school does not offer insurance

The department does not plan to seek this amendment.
Allowing full time students to enroll in the waiver would cause a large population shift within PCN from former UMAP clients (low income adults without dependent children) to students.

- Allow clients 60 or 90 days to pay their enrollment fee, instead of 30 days

The department does not plan to seek this amendment.
The department believes 30 days is a sufficient amount of time to pay the enrollment fee because the 30 day clock starts after notification of eligibility not date of application.

- Open eligibility for the client effective the month they pay their enrollment fee. For example, if the client applied for PCN in January, but did not pay their enrollment fee until March, the benefit start date would be March and they would receive PCN for 12 months from March

The department does not plan to seek this amendment.
The effective date of coverage will continue to be the date of application. The department believes this policy is necessary to stay consistent with other department programs.

**Non-Traditional**

- Increase pharmacy co-payment from $2 to $3

The department plans to seek this amendment.
This change would make the pharmacy co-payment for Non-Traditional and Traditional Medicaid the same.

- Increase $6 co-pay for non-emergency use of the ER

The department does not plan to seek this amendment.
The department believes that federal regulations limit our ability to increase this co-payment.

- PDL

The department does not plan to seek this amendment.
The department will use PCN to pilot a PDL. The department will reconsider this option in another year after observing the PCN PDL.

**Financial**

- Attempt to amend cost neutrality agreement

The department is still considering this proposed amendment.
The department operates within two financial constraints – state funds and federal cost neutrality. The current cost neutrality agreement with the federal government may not reflect the full available allowances for enrolled individuals.

- Seek federal match for inpatient physician fees

The department plans to seek this amendment.
Currently these services are paid by state funds only. The current positive balance in the cost neutrality agreement will allow the state to obtain matching federal funds, which will reduce the cost in state dollars. The state dollars may be used to provide other PCN benefits or may be redirected by the Legislature. *Note – This amendment would likely be contingent on hospitals continuing to provide donated inpatient care.*